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emailed validation letter 12/6/10

Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 12.1.10
Amount $930.-

Ck #35792

## I. IDENTIFICATION

Name Central City Enterprises, Inc. Belle Meade Home

Address 521 Greene Drive, P.O. Box 565

City/County/Zip Greenville, KY 42345 Muhlenberg County

Telephone number 270-338-1523

Administrator Gregory Sparks

Date facility operation began at current address 3/1/1967

Date facility began operation under current owner 3/1/1967

## II. TYPE BEDS

| | No. beds licensed | No. beds requested |
|---|---|---|
| Skilled | | |
| Nursing Home | | |
| Nursing Facility | 62 | 62 |
| Intermediate Care | | |
| ICF/MR | | |
| Personal Care | | |

## II. CONTROL (check one in each column)

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation

## II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Gregory Sparks P.O. Box 565 Greenville, KY 42345

(OVER)

11/30

If facility owned or leased by a corporation, complete the following:

Name of corporation Central City Enterprises, Inc.

Address of corporation 521 Greene Drive Greenville, KY 42345

President or Chairman Gregory Sparks

Vice President Beau Sparks

Secretary Muriel McRoy

Treasurer Muriel MCRoy

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

| Parent | Management Company |
|---|---|
| | |
| | |
| | |

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative

Administrator
Title

11/17/10
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)